Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON COMMUNITY HOSPITAL
C/O BURTON & HYDE
311 W 5TH STREET SUITE 100
AUSTIN TX 78701

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 19

Respondent Name
GRAY INSURANCE CO INC

MFDR Received Date
FEBRUARY 2, 2004

MFDR Tracking Number
M4-11-1307-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Houston Community Hospital is submitting the TWCC 60 because we feel that Gray Insurance Company is in violation of TWCC Rules: 133.301(a); 133.300(a) and 133.304(a). Houston Community Hospital received a verbal denial on claim due to Peer Review. The Peer Review was performed on 10/22/2003. This is 5 months after date of service. This claim was an authorized procedure by the insurance carrier's representative-Forte. The carrier filed a BRC disputing they were responsible for payment on claim. The BRC had been rescheduled numerous times, with the final Hearing on 10/29/2003. It is also believed that the rescheduling of the BRC and the up and coming Peer Review was used to delay payment on this claim. Once verbal confirmation was received that Gray Insurance was responsible for the claim, a Request for Reconsideration was again submitted. Carrier denied the final Reconsideration. Enclosed is a copy of the authorization letter for the above date of service."

Amount in Dispute: $9,449.85*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is re-auditing the disputed bill and will pay according to the re-audit. Please see the attached EOR. Carrier will supplement this response with the payment information."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2003	Outpatient Surgery	$9,449.85*	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on February 2, 2004.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W3 – Additional payment made on appeal/reconsideration.
   - W7 – Payment of interest/penalty to provider.
   - O – Previously recommended amount has not been changed.
   - V – Payment has been denied because the treatment &/or services appear to be medically unreasonable &/or unnecessary based on a peer review.
   - G – Procedure disallowed: Bundled w/another procedure billed for same DOS.
6. *The respondent issued a payment, in the amount of $2,116.62 on January 28, 2011. The payment amount included an interest payment of $461.47; this amount was subtracted for the total amount leaving a payment amount for the entire bill of $9,449.85.

Findings

1. The carrier denied services using the denial code V – "Payment has been denied because the treatment &/or services appear to be medically unreasonable &/or unnecessary based on a peer review." Review of the explanation of benefits with audit date January 28, 2011 finds that the carrier did not maintain this denial reason upon reconsideration. The Division therefore concludes that this denial reason is not supported. The services will be reviewed per applicable statutes and Division rules.
2. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.